DIAGNOSTIC IMAGING
of SOUTHBURY

Your health, your choice.

RECEIVED
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CONNECTICUT OFFICE OF
HEALTH CARE ACCESS

June 1, 2006

Cristine A. Vogel, Commissioner
Office of Health Care Access
410 Capital Avenue, MS #13HCA
P.O. Box 340308
Hartford, Connecticut 06134-0308

Dear Commissioner Vogel:

I am enclosing an original plus three copies of a Letter of Intent/Waiver Form (2030) for Diagnostic Imaging of Southbury, LLC to acquire and operate a mobile PET/CT Scanner one day a week.

Should you have any questions regarding this Letter of Intent please do not hesitate to contact me at (203) 267-3340.

Sincerely,

Robert Gumbardo, M.D.
Chairman and Co-Medical Director
Diagnostic Imaging of Southbury LLC

Enclosure

State of Connecticut
Office of Health Care Access
Letter of Intent/Waiver Form
Form 2030

All Applicants must complete a Letter of Intent (LOI) form prior to submitting a Certificate of Need application, pursuant to Sections 19a-638 and 19a-639 of the Connecticut General Statutes and Section 19a-643-79 of OHCA's Regulations. Please submit this form to the Commissioner of the Office of Health Care Access, 410 Capitol Avenue, MS# 13HCA, P.O. Box 340308, Hartford, Connecticut 06134-0308.

SECTION I. APPLICANT INFORMATION

If there are more than two Applicants, please attach a separate sheet of paper and provide additional information in the format below.

	Applicant One	Applicant Two
Full legal name	**Diagnostic Imaging of Southbury, LLC**	
Doing Business As		
Name of Parent Corporation	**Not Applicable**	
Mailing Address, if Post Office Box, include a street mailing address for Certified Mail	**385 Main St South Union Square Bldg. #2 Southbury, CT 06488**	
Applicant type (e.g., profit/non-profit)	**For Profit**	
Contact person, including title or position	**Paul Masotto, Adminstrative Director, DIS, Robert Gumbardo, M.D., Chairman, Co-Medical Director, DIS**	
Contact person's street mailing address	**385 Main St South Union Square Bldg. #1 Southbury, CT 06488**	
Contact person's phone #, fax # and e-mail address	**Tele: 203 267-3340 Ext 1101 Fax: 203 267-3342 pmasotto@nvranet.com rgumbardo@nvranet.com**	

SECTION II. GENERAL APPLICATION INFORMATION

a. Proposal/Project Title: **Acquisition and Operation of a Mobile PET/CT Scanner**

b. Type of Proposal, please check all that apply:

☒ Change in Facility (F), Service (S) or Function (Fnc) pursuant to Section 19a-638, C.G.S.:

☒ New (F, S, Fnc)	☐ Replacement	☒ Additional (F, S, Fnc)
☐ Expansion (F, S, Fnc)	☐ Relocation	☐ Service Termination
☐ Bed Addition`	☐ Bed Reduction	☐ Change in Ownership/Control

☒ Capital Expenditure/Cost, pursuant to Section 19a-639, C.G.S.:

☐ Project expenditure/cost cost greater than $ 1,000,000

☒ Equipment Acquisition greater than $ 400,000

☒	New	☐	Replacement	☐	Major Medical
☒	Imaging	☐	Linear Accelerator		

☐ Change in ownership or control, pursuant to Section 19a-639 C.G.S., resulting in a capital expenditure over $1,000,000

c. Location of proposal (Town including street address): **385 Main Street South, Union Square, Building #2, Southbury, Connecticut 06488**

d. List all the municipalities this project is intended to serve: **Primarily the towns of Southbury, Woodbury, Newtown, Waterbury, and Oxford. The expanded service area includes Middlebury, Bethlehem, Watertown, and Naugatuck.**

e. Estimated starting date for the project: **October 1, 2006**

f. Type of project: **_20, 21, 24__(Fill in the appropriate number(s) from page 7 of this form)**

Number of Beds (to be completed if changes are proposed)

Type	Existing Staffed	Existing Licensed	Proposed Increase (Decrease)	Proposed Total Licensed
N/A				

SECTION III. ESTIMATED CAPITAL EXPENDITURE INFORMATION

a. Estimated Total Capital Expenditure: **$ 549,200**

b. Please provide the following breakdown as appropriate:

Construction/Renovations	$
Medical Equipment (Purchase)	
Imaging Equipment (Purchase)	
Non-Medical Equipment (Purchase)	$ 50,000
Sales Tax	
Delivery & Installation	
Total Capital Expenditure	**$ 50,000**
Fair Market Value of Leased Equipment	$499,200
Total Capital Cost	**$549,200**

Major Medical and/or Imaging equipment acquisition:

Equipment Type	Name	Model	Number of Units	Cost per unit
PET CT (Mobile)	Philips	Gemini	1	$2,400,000

Note: Provide a copy of the contract with the vendor for major medical/imaging equipment.

Response: A copy of the vendor contract will be submitted with the CON Application.

c. Type of financing or funding source (more than one can be checked):

[X]	Applicant's Equity	[X]	Lease Financing	[ ]	Conventional Loan
[ ]	Charitable Contributions	[ ]	CHEFA Financing	[ ]	Grant Funding
[ ]	Funded Depreciation	[ ]	Other (specify): _____		

SECTION IV. PROJECT DESCRIPTION

Please attach a separate 8.5" X 11" sheet(s) of paper and provide no more than a 2 page description of the proposed project, highlighting all the important aspects of the proposed project. Please be sure to address the following (if applicable):

1. Currently what types of services are being provided? If applicable, provide a copy of each Department of Public Health license held by the Petitioner.
2. What types of services are being proposed and what DPH licensure categories will be sought, if applicable?
3. Who is the current population served and who is the target population to be served?
4. Identify any unmet need and how this project will fulfill that need.
5. Are there any similar existing service providers in the proposed geographic area?
6. What is the effect of this project on the health care delivery system in the State of Connecticut?
7. Who will be responsible for providing the service?
8. Who are the payers of this service?

If requesting a Waiver of a Certificate of Need, please complete Section V.

SECTION V. WAIVER OF CON FOR REPLACEMENT EQUIPMENT

I may be eligible for a waiver from the Certificate of Need process because of the following: (Please check all that apply)

☐ This request is for Replacement Equipment.

- ☐ The original equipment was authorized by the Commission/OHCA in Docket Number: _____.
- ☐ The cost of the equipment is not to exceed $2,000,000.
- ☐ The cost of the replacement equipment does not exceed the original cost increased by 10% per year.

Please complete the attached affidavit for Section V only.

AFFIDAVIT

Applicant: **Diagnostic Imaging of Southbury, LLC**

Project Title: **Acquisition and Operation of a Mobile PET/CT Scanner**

I, Robert Gumbardo, M.D., (Name) Chairman (Position – CEO or CFO)

of Diagnostic Imaging of Southbury, LLC being duly sworn, depose and state that the information provided in this CON Letter of Intent/Waiver Form (2030) is true and accurate to the best of my knowledge, and that Diagnostic Imaging of Southbury, LLC (Facility Name) complies with the appropriate and applicable criteria as set forth in the Sections 19a-630, 19a-637, 19a-638, 19a-639, 19a-486 and/or 4-181 of the Connecticut General Statutes.

Signature

6-13-06
Date

Subscribed and sworn to before me on June 13, 2006

Deborah E Shupenis
Notary Public/Commissioner of Superior Court

My commission expires: _____

DEBORAH E. SHUPENIS
NOTARY PUBLIC
My Commission Expires June 30, 2010

Project Type Listing

Please indicate the number or numbers of types of projects that apply to your request on the line provided on the Letter of Intent Form (Section II, page 2).

Inpatient

1. Cardiac Services
2. Hospice
3. Maternity
4. Med/ Surg.
5. Pediatrics
6. Rehabilitation Services
7. Transplantation Programs
8. Trauma Centers
9. Behavioral Health (Psychiatric and Substance Abuse Services)
10. Other Inpatient

Outpatient

11. Ambulatory Surgery Center
12. Birthing Centers
13. Oncology Services
14. Outpatient Rehabilitation Services
15. Paramedics Services
16. Primary Care Clinics
17. Urgent Care Units
18. Behavioral Health (Psychiatric and Substance Amuse Services)
19. MRI
20. CT Scanner
21. PET Scanner
22. Other Imaging Services
23. Lithotripsy
24. Mobile Services
25. Other Outpatient
26. Central Services Facility

Non-Clinical

27. Facility Development
28. Non-Medical Equipment
29. Land and Building Acquisitions
30. Organizational Structure (Mergers, Acquisitions, Affiliations, and Changes in Ownership)
31. Renovations
32. Other Non-Clinical

Diagnostic Imaging of Southbury, LLC
Acquisition and Operation of a Mobile PET/CT Scanner

Project Description

Diagnostic Imaging of Southbury, LLC ("DIS") is a limited liability company, whose Members include St. Mary's Hospital, Naugatuck Valley Radiology Associates, PC, and Northeast Radiology, PC. The imaging center offers comprehensive services including the modalities of diagnostic radiography, fluoroscopic radiology, CT, ultrasound, mammography, bone densitometry, nuclear medicine, and high field MRI.

DIS is submitting this Letter of Intent to expand its services through the acquisition and operation of a Positron Emission Tomography and Computed Tomography ("PET/CT") Scanner.

This project would involve the leasing of a mobile Philips Gemini Open PET/CT scanner one day a week from Mobile PET/T Associates, LLC ("Integral Mobile".) Integral Mobile is a Pennsylvania limited liability company engaged in the business of providing PET/CT scanning services.

The mobile PET/CT Scanner would be located in Union Square Plaza between Building 1 and 2 for easy and convenient access for DIS' patients. The necessary concrete docking pad, power supply, data and phone connectivity were installed previously for a mobile MRI unit so the project costs for installation are reduced significantly. The non medical equipment required for this project consists of the computer hardware and software needed to integrate this service into the existing information system network.

The incorporation of PET/CT Services will provide DIS with the functionality to expand its imaging services and provide new procedures in the areas of oncology, cardiology, neurology, and psychiatry. The demand for PET/CT imaging continues to grow nationally and is predicted to increase over 50% annually for the next several years. This project would provide DIS' existing and future patient population convenient access to advanced diagnostic services.

DIS is currently licensed by the Department of Public Health. No changes to that license will be sought as a result of this project.

Integral Mobile will be responsible for the operation and maintenance of the equipment and performance of the scans. DIS' physicians will be responsible for the interpretation of all PET/CT scans performed on the unit. DIS is the entity that will bill for the PET/CT services and receive payments for those services. Anticipated payer sources include Medicare, Medicaid, self pay, commercial, and managed care payers. The target population for this proposal is DIS' existing patient base: residents primarily from the towns of Southbury, Woodbury, Newtown, Waterbury, and Oxford.

This project will positively impact on the health care delivery system in the State of Connecticut by improving quality of care for DIS' patients as measured by accessibility to the current standard of care for PET/CT services.

Healthcare providers, operating in the proposed service area, that offer PET Services include Waterbury Hospital, St. Mary's Hospital, and the Harold Leever Regional Cancer Center.

STATE OF CONNECTICUT

OFFICE OF HEALTH CARE ACCESS

M. JODI RELL
GOVERNOR

CRISTINE A. VOGEL
COMMISSIONER

June 21, 2006

Paul Masotto
Executive Director, NVRA/CRN
Diagnostic Imaging of Southbury, LLC
385 Main Street-South Suite 209 Bldg 1
Southbury, CT 06488

Re: Letter of Intent, Docket Number 06-30768
Diagnostic Imaging of Southbury, LLC
Acquisition and Operation of a Mobile PET-CT Scanner
Notice of Letter of Intent

Dear Mr. Masotto:

On June 16, 2006, the Office of Health Care Access ("OHCA") received the Letter of Intent ("LOI") Form of Diagnostic Imaging of Southbury, LLC("Applicant") for the acquisition and operation of a mobile PET-CT scanner, at a total capital expenditure of $549,200.

A notice to the public regarding OHCA's receipt of a LOI was published in *The News Times* pursuant to Section 19a-638 & 19a-639 of the Connecticut General Statutes. Enclosed for your information is a copy of the notice to the public.

Sincerely,

Kimberly R. Martone
Certificate of Need Supervisor

KRM:SL:dpd

STATE OF CONNECTICUT

OFFICE OF HEALTH CARE ACCESS

M. JODI RELL
GOVERNOR

CRISTINE A. VOGEL
COMMISSIONER

June 21, 2006

Requisition # HCA07-009
FAX #: (203) 792-4211

The News Times
333 Main Street
Danbury, CT 06810

Gentlemen/Ladies:

Please make an insertion of the attached copy, in a single column space, set solid under legal notices, in the issue of your newspaper by no later than Sunday, June 25, 2006.

Please fax evidence that the legal notice was published by the date requested above to (860) 418-7053. In addition, please send the original legal notice (full tear sheet is required) with the invoice.

If there are any questions regarding this legal notice, please contact Steven Lazarus at (860) 418-7001.

KINDLY RENDER BILL IN DUPLICATE ATTACHED TO THE TEAR SHEET.

Sincerely,

Kimberly R. Martone
Certificate of Need Supervisor

Attachment

KRM:SL:dpd

c: Sandy Salus, OHCA

The News Times
Docket Number 06-30768-LOI

Letter of Intent
June 21, 2006

PLEASE INSERT THE FOLLOWING:

Applicant:	Diagnostic Imaging of Southbury, LLC
Town:	Southbury
Docket Number:	06-30768-LOI
Proposal:	Acquisition and Operation of a Mobile PET-CT Scanner
Total Capital Expenditure:	$549,200

The Applicant may file its Certificate of Need application between August 15, 2006 and October 14, 2006. Interested persons are invited to submit written comments to Cristine A. Vogel, Commissioner Office of Health Care Access, 410 Capitol Avenue, MS13HCA P.O. Box 340308 Hartford, CT 06134-0308.

The Letter of Intent is available for inspection at OHCA. A copy of the Letter of Intent or a copy of Certificate of Need Application, when filed, may be obtained from OHCA at the standard charge. The Certificate of Need application will be made available for inspection at OHCA, when it is submitted by the Applicant.

****
*** TX REPORT ***
****

TRANSMISSION OK

TX/RX NO	0843
RECIPIENT ADDRESS	912037924211
DESTINATION ID	
ST. TIME	06/21 15:21
TIME USE	00'21
PAGES SENT	2
RESULT	OK

STATE OF CONNECTICUT

OFFICE OF HEALTH CARE ACCESS

M. JODI RELL
GOVERNOR

CRISTINE A. VOGEL
COMMISSIONER

June 21, 2006

Requisition # HCA07-009
FAX #: (203) 792-4211

The News Times
333 Main Street
Danbury, CT 06810

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KINDLY RENDER BILL IN DUPLICATE ATTACHED TO THE TEAR SHEET.

Sincerely,

Kimberly R. Martone
Certificate of Need Supervisor

STATE OF CONNECTICUT

OFFICE OF HEALTH CARE ACCESS

M. JODI RELL
GOVERNOR

CRISTINE A. VOGEL
COMMISSIONER

June 22, 2006

Paul Masotto
Executive Director, NVRA/CRN
Diagnostic Imaging of Southbury, LLC
385 Main Street South
Suite 209 Bldg 1
Southbury, CT 06488

RE: Certificate of Need Application Forms, Docket Number 06-30768-CON
Diagnostic Imaging of Southbury, LLC
Acquisition and Operation of a Mobile PET-CT Scanner

Dear Mr. Masotto:

Enclosed are the application forms for Diagnostic Imaging of Southbury, LLC's Certificate of Need ("CON") proposal for the Acquisition and Operation of a Mobile PET-CT Scanner with an associated capital expenditure of $2,450,000. According to the parameters stated in Sections 19a-638 and 19a-639of the Connecticut General Statutes the CON application may be filed between August 15, 2006, and October 14, 2006.

When submitting your CON Application, please paginate and date each page contained in your submission. In addition, please submit one (1) original and five hard copies; as well as a scanned copy of the complete Application, including all attachments, on CD or Diskette. OHCA requests a copy of the submission be in MS Word format and the scanned copy be in Adobe format. Please submit the Financial Attachment and other data as appropriate in MS Excel format.

The analyst assigned to the CON application is Steven W. Lazarus. Please feel free to contact him/her at (860) 418-7012, if you have any questions.

Sincerely,

Kimberly Martone
Certificate of Need Supervisor

Enclosures

OFFICE OF HEALTH CARE ACCESS

REQUEST FOR NEW CERTIFICATE OF NEED

FILING FEE COMPUTATION SCHEDULE

APPLICANT: _____ PROJECT TITLE: _____ DATE: _____	FOR OHCA USE ONLY: DATE INITIAL 1. Check logged (Front desk) _____ _____ 2. Check rec'd (Clerical/Cert.) _____ _____ 3. Check correct (Superv.) _____ _____ 4. Check logged (Clerical/Cert).) _____ _____

SECTION A – NEW CERTIFICATE OF NEED APPLICATION	
1. Check statute reference as applicable to CON application (see statute for detail):	
_____ 19a-638.Additional function or service, Change of Ownership, Service Termination. **No Fee Required.**	
_____ 19a-639 Capital expenditure for major medical equipment, imaging equipment or linear accelerator exceeding $400,000 but less than or equal to $1,000,000. **Fee Required.**	
_____ 19a-639 Capital expenditure for major medical equipment, imaging equipment or linear accelerator exceeding $1,000,000 or other capital expenditure exceeding $1,000,000. **Fee Required.**	
_____ 19a-638 and 19a-639. **Fee Required.**	
2. Enter $0 on "Total Fee Due" line (SECTION B) if application is required pursuant to Section 19a-638 only, otherwise go on to line 3 of this section.	
3. Enter $400 on "Total Fee Due" line (SECTION B) if application is for capital expenditure for major medical equipment, imaging equipment or linear accelerator exceeding $400,000 but less than or equal to $1,000,000	
4. Section 19a-639 fee calculation (applicable if section 19a-639 capital expenditure for major medical equipment, imaging equipment or linear accelerator exceeding $1,000,000 or other capital expenditure exceeding $1,000,000 is checked above **OR** if both 19a-638 and 19a-639 are checked):	
a. Base fee: _____	$ 1,000.00
b. Additional Fee: (Capital Expenditure Assessment)_____ (To calculate: Total requested Capital Expenditure/Cost excluding capitalized financing costs multiplied times .0005 and round to nearest dollar.) ($_____ x .0005)	$_____.00 $_____.00
c. Sum of base fee plus additional fee: (Lines A3a + A3b)_____	
d. Enter the amount shown on line A3c. on "Total Fee Due" line (SECTION B).	
SECTION B TOTAL FEE DUE: _____	$_____.00

ATTACH HERE CERTIFIED OR CASHIER'S CHECK ONLY (Payable to: Treasurer, State of Connecticut)

GENERAL AFFIDAVIT

Applicant: _____

Project Title: _____

I, _____, _____
(Name) (Position – CEO or CFO)

of _____ being duly sworn, depose and state that the (Facility Name) said facility complies with the appropriate and applicable criteria as set forth in the Sections 19a-630, 19a-637, 19a-638, 19a-639, 19a-486 and/or 4-181 of the Connecticut General Statutes.

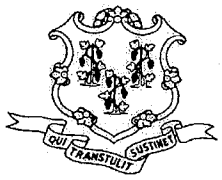
_____ _____
Signature Date

Subscribed and sworn to before me on_____

_____

Notary Public/Commissioner of Superior Court

My commission expires: _____



State of Connecticut
Office of Health Care Access
Certificate of Need Application

Please complete all questions. If any question is not relevant to your project, Not Applicable may be an acceptable response. Your Certificate of Need application will be eligible for submission no earlier than August 15, 2006, and may be submitted no later than October 14, 2006. The Analyst assigned to your application is Steven W. Lazarus and may be reached at the Office of Health Care Access at (860) 418-7001.

Docket Number: 06-30768-CON

Applicant Name: Diagnostic Imaging of Southbury, LLC

Contact Person: Paul Masotto
Contact Title: Executive Director, NVRA/CRN
Diagnostic Imaging of Southbury, LLC
Contact Address: 385 Main Street South Suite 209 Bldg 1
Southbury, CT 06488

Project Location: Southbury

Project Name: Acquisition and Operation of a Mobile PET-CT Scanner

Type proposal: Sections 19a-638 and 19a-639, C.G.S.

Est. Capital Expenditure: $2,450,000

1. Expansion of Existing or New Service

What services are currently offered at your facility that the proposed expansion or new service will augment or replace? Please list.

Augment: _____

_____

Replace: _____

_____

2. State Health Plan

No questions at this time.

3. Applicant's Long Range Plan

Is this application consistent with your long-range plan?

☐ Yes ☐ No

If "No" is checked, please provide an explanation.

4. Clear Public Need

Note: Sections 19a-634 and 19a-637 of the Connecticut General Statutes specifically mandate that OHCA consider the availability, scope and need for services for the residents of Connecticut. Therefore, OHCA does not consider out-of-state volume in its evaluation of need for the proposed service.

A. Explain how it was determined there was a need for the proposal in your service area.

i) Provide the following information:
   a) Primary and secondary service area towns
   b) If existing facility/service, the unit of service (i.e. procedure, scan, visit, etc.) for the past three fiscal years by service area town
   c) If new facility/service, the population to be served, including the number of individuals to receive the proposed service(s). Include demographic Information, as appropriate.
   d) Scheduling backlogs in service area
   e) Travel distance from proposed site to service area towns
   f) Hours of operation of existing/proposed service

ii) What will be the effect of your proposal on existing providers (i.e. patient volume, financial stability, quality of care, etc.)?

iii) Provide the units of service projected for the first three years of operation of the proposed service. **Include the derivation/calculation.**

iv) Provide the information as outlined in the following table concerning the existing providers' (in the Applicant's Primary Service Area) current operations:

Description of Service[1]	Provider Name and Location	Hours and Days of Operation[2]	Current Utilization[3]

[1] If proposal concerns imaging equipment, provide a description of the equipment used by the Provider, if known. For MRI scanners, include Tesla strength, and whether or not the scanner is considered to be "open" or "closed".
[2] Specify days of the week and start and end time for each day.
[3] Number of scans performed on specified scanner by Provider for the most recent 12 month period, if known.

v) Provide the hours of operation for the proposed PET/CT scanner.

vi) What is the projected number of PET scans that will be used for specifically for detecting metastatic disease by the hospital? Will this use relate to a reduction in other imaging modalities?

B. Will your proposal remedy any of the following barriers to access? Please provide an explanation.

☐ Cultural ☐ Transportation

☐ Geographic ☐ Economic

☐ None of the above ☐ Other (Identify) _____

If you checked other than None of the above, please provide an explanation.

C. Provide copies of any of the following plans, studies or reports related to your proposal:

☐ Epidemiological studies ☐ Needs assessments

☐ Public information reports ☐ Market share analysis

☐ Other (Identify) _____

☐ None: *explain* why no reports, studies or market share analysis was undertaken related to the proposal:

_____
_____
_____
_____

5. Quality Measures

A. If the proposal is for a new technology or procedure, have all appropriate agencies approved the proposed procedure (e.g., FDA etc.)?

☐ Yes ☐ No ☐ Not Applicable

If "No", please provide an explanation.

B. Check off all the Standard of Practice Guidelines that will be utilized by the Applicant for the proposed service. Please submit the most recent copy of each report related to the proposal:

☐ American College of Cardiology	☐ National Committee for Quality Assurance	☐ Public Health Code & Federal Corollary
☐ National Association of Child Bearing Centers	☐ American College of Obstetricians & Gynecologists	☐ American College of Surgeons
☐ Report of the Inter-Council for Radiation Oncology	☐ American College of Radiology	☐ Substance Society Abuse and Mental Health Services Administration

☐Other: Specify _____

C. Describe in detail how the Applicant plans to meet the each of the guidelines checked off above.

D. Submit a list of **all** key professional and administrative personnel, including the Applicant's Chief Executive Officer (CEO) and Chief Financial Officer (CFO), Medical Director, physicians, nurses, therapists, counselors, etc., related to the proposal and a copy of their Curriculum Vitae.
Note: For physicians, please provide a list of hospitals where the physicians have admitting privileges.

E. Provide a copy of the most recent inspection reports and/or certificate for your facility:

☐	DPH	☐	JCAHO
☐	Fire Marshall Report	☐	Other States Health Dept. Reports (new out-of-state providers)
☐	AAAHC	☐	AAAASF
☐	Other: _____		

Note: Above referenced acronyms are defined below. [1]

F. Provide a copy of the following (as applicable):

☐ A copy of the related Quality Assurance plan

☐ Protocols for service (new service only)

☐ Patient Selection Criteria/Intake form

[1] DPH – Department of Public Health; JCAHO – Joint Commission on Accreditation of Hospitals Organization; AAAHC – Accreditation Association for Ambulatory Health Care, AAAASF – American Association for Accreditation of Ambulatory Surgery Facilities, Inc.

6. Improvements to Productivity and Containment of Costs

In the past year has your facility undertaken any of the following activities to improve productivity and contain costs?

☐ Energy conservation ☐ Group purchasing

☐ Reengineering ☐ None of the above

☐ Application of technology (e.g., computer systems, robotics, telecommunication systems, etc.)

☐ Other (identify)_____

7. Miscellaneous

A. Will this proposal result in new (or a change to) your teaching or research responsibilities?

☐ Yes ☐ No

If you checked "Yes," please provide an explanation.

B. Are there any characteristics of your patient/physician mix that makes your proposal unique?

☐ Yes ☐ No

If you checked "Yes," please provide an explanation.

C. Provide the following licensing information:

i) If you are currently licensed, provide a copy of the State of Connecticut Department of Public Health license currently held.

ii) The DPH licensure category you are seeking. If not applicable, please explain why.

8. Financial Information

A. Type of ownership: (Please check off all that apply)

☐ Corporation (Inc.) ☐ Limited Liability Company (LLC)

☐ Partnership ☐ Professional Corporation (PC)

☐ Joint Venture ☐ Other (Specify):

_____

B. Provide the following financial information:

i) If the Applicant is not a hospital, please submit the Applicant's audited financial statements for the most recently completed fiscal year. If the Applicant has no audited financial statements, please submit a compilation report or an unaudited Balance Sheet and Statement of Operations for the most recently completed fiscal year. These statements should be externally prepared and submitted on the preparer's letterhead.

ii) Identify the entity that will be billing for the proposed service.

9. Major Cost Components/Total Capital Expenditure

Submit a final version of all capital expenditures/costs as follows:

Medical Equipment (Purchase)	
Major Medical Equipment (Purchase)	
Non-Medical Equipment (Purchase)*	
Land/Building (Purchase)	
Construction/Renovation	
Other (Non-Construction) Specify:_____	
Total Capital Expenditure	
Medical Equipment (Lease (FMV))	
Major Medical Equipment (Lease (FMV)	
Non-Medical Equipment (Lease (FMV))*	
Fair Market Value of Space – (Capital Leases Only)	
Total Capital Cost	
Capitalized Financing Costs (Informational Purpose Only)	
Total Capital Expenditure with Cap. Fin. Costs	

* Provide an itemized list of all non-medical equipment.

10. Capital Equipment Lease/ Purchase

If the CON involves any capital equipment lease and/or purchase, please answer all of the following that apply:

What is the anticipated residual value at the end of the lease or loan term?	$_____
What is the useful life of the equipment?	___ Years
Please submit a copy of the vendor quote or invoice as an attachment.	
Please submit a schedule of depreciation for the purchased equipment as an attachment.	

For multiple items, please attach a separate sheet for each item in the above format.

11. Type of Financing

A. Check type of funding or financing source and identify the following anticipated requirements and terms: (Check all which apply)

☐ Applicant's equity:

Source and amount:

Operating Funds Source/Entity Name Available Funds	$_____ _____
Contributions	$_____
Funded depreciation	$_____
Other	$_____

☐ Grant:

Amount of grant	_____
Funding institution/ entity	_____

☐ Conventional loan or
☐ Connecticut Health and Educational Facilities Authority (CHEFA) financing:

Current CHEFA debt	
CON Proposed debt financing	
Interest rate	%
Monthly payment	
Term	Years
Debt service reserve fund	

☐ Lease financing or
☐ CHEFA Easy Lease Financing:

Current CHEFA Leases	
CON Proposed lease financing	
Fair market value of leased assets at lease inception	
Interest rate	%
Monthly payment	
Term	Years

☐ Other financing alternatives:

Amount	
Source (e.g., donated assets, etc.)	

B. Please provide copies of the following, if applicable:
i. Letter of interest from the lending institution,
ii. Letter of interest from CHEFA,
iii. Amortization schedule (if not level amortization payments),
iv. Lease agreement.

12. Revenue, Expense and Volume Projections

A.1. Payer Mix Projection

Please provide both the current payer mix and the projected payer mix with the CON proposal for the Total Facility based on Net Patient Revenue in the following reporting format:

Total Facility Description	Current Payer Mix	Year 1 Projected Payer Mix	Year 2 Projected Payer Mix	Year 3 Projected Payer Mix
Medicare*	%	%	%	%
Medicaid* (includes other medical assistance)				
CHAMPUS and TriCare				
Total Government Payers				
Commercial Insurers*				
Uninsured				
Workers Compensation				
Total Non-Government Payers				
Payer Mix	100.0%	100.0%	100.0%	100.0%

*Includes managed care activity.

A.2. Please describe the impact of the proposal on the interests of consumers of health care services and the payers of such services.

B. Does the Applicant have Tax Exempt Status? ☐ Yes ☐ No

C. Provide the following for the financial and statistical projections:

i) A summary of revenue, expense and volume statistics, without the CON project, incremental to the CON project, and with the CON project. **See attached.** Please note that the actual results for the fiscal year reported in the first column must agree with the Applicant's audited financial statements.

ii) The assumptions utilized in developing the projections (e.g., FTE's by position, volume statistics, other expenses, revenue and expense % increases, project commencement of operation date, etc.).

iii) An explanation for any projected incremental losses from operations contained in the financial projections that result from the implementation and operation of the CON proposal.

iv) Provide a copy of the rate schedule for the proposed service.

v) Describe how this proposal is cost effective.

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12. C (i). Please provide one year of actual results and three years of projections of **Total Facility** revenue, expense and if applicable, volume statistics without, incremental to and with the proposal in the following reporting format:

Total Facility:	FY	FY	FY	FY	FY	FY	FY	FY	FY	FY
	Actual	**Projected**	**Projected**	**Projected**	**Projected**	**Projected**	**Projected**	**Projected**	**Projected**	**Projected**
Description	**Results**	**W/out Project**	**Incremental**	**With Project**	**W/out Project**	**Incremental**	**With Project**	**W/out Project**	**Incremental**	**With Project**
Revenue from Operations				$0			$0			$0
Non-Operating Revenue				$0			$0			$0
Total Revenue:	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Total Operating Expenses				$0			$0			$0
Income before provision for income taxes	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Provision for income taxes				$0			$0			$0
Net Income	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Retained earnings, beginning of year		$0	$0	$0	$0	$0	$0	$0	$0	$0
Retained earnings, end of year	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0

*Volume Statistics:

*Provide projected inpatient and/or outpatient statistics for any new services and provide actual and projected inpatient and/or outpatient statistics for any existing services which will change due to the proposal.